BOARD OF PSYCHOLOGY
1422 Howe Avenue, Ste. 22, Sacramento, CA 95825

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: Date of Birth:

I, the undersigned hereby authorize:

1. _____
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2. _____
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3. _____
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4. _____
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to disclose records made in the course of my diagnosis and treatment, to include medical, psychiatric, alcohol and drug abuse records, to the CALIFORNIA BOARD OF PSYCHOLOGY & MEDICAL BOARD OF CALIFORNIA , ENFORCEMENT PROGRAM. This disclosure of records authorized herein is required for official use including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the California Board of Psychology/Medical Board of California completes its investigation and proceedings arising out of the investigations.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Board of Psychology, 1422 Howe Avenue, Ste. 22, Sacramento, CA 95825. My written revocation will be effective upon receipt by the California Board of Psychology but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

Signature:_____ _____
Patient Date

_____ _____
Legal Representative Relationship Date
(Sign here only if you are NOT the patient)

NOTE: Failure by a psychologist to provide the requested records within 15 days, or a health care facility in 30 days, of receipt of this request and authorization may constitute a violation of Section 2969, of the Business and Professions Code. This release is compliant with the requirements of HIPAA and Civil Code Section 56.11.